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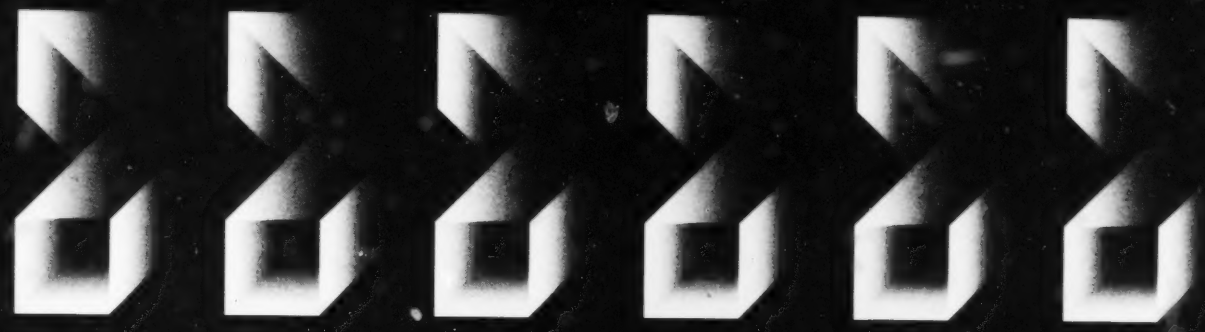

EVALUATION OF HEALTH INSURANCE MONITORING

July 1994

Canada

MISSION STATEMENT

The Program Evaluation Division helps Health Canada serve Canadians better by providing objective information and advice about the effectiveness of departmental activities and services.

ÉNONCÉ DE MISSION

La Division de l'évaluation des programmes aide Santé Canada à mieux servir les Canadiens et les Canadiennes en offrant une information et des conseils objectifs sur l'efficacité des activités et des services du Ministère.

EXECUTIVE SUMMARY

This report presents the results of a study undertaken to assess the effectiveness with which the Health Insurance Directorate carries out its role in monitoring and assessing the compliance of provincial health care plans with the criteria and conditions specified in the Canada Health Act.

The Canada Health Act specifies five criteria and two conditions that provincial health care plans have to meet in order to receive financial transfers from the federal government. The criteria are: public administration, comprehensiveness, universality, portability and accessibility. The two conditions are the provision of information by the provinces and their recognition of the federal contributions to health care. Provinces permitting user charges for hospital services and/or extra-billing by physicians are subject to specific financial penalties under the Act.

The study consisted primarily of a review of the literature and other available documentation, a review of program files and documents and of interviews with the Health Insurance Directorate and other Health and Welfare Canada officials. Provinces and organizations external to the Department were not contacted for this study with the exception of the Canadian Nurses Association.

Following are the general conclusions of the study.

1. The Health Insurance Directorate has a procedure to monitor and assess compliance of the provincial plans. The study was unable to identify cases of non compliance other than those already identified by the Directorate. The positions taken on issues have been consistent over time as well as across provinces and within ministerial policies. The Directorate has also informed the higher authorities of the Department about cases of possible non-compliance. Given the context in which it operates, the Directorate has been fulfilling its mandate effectively.

2. The Canada Health Act recognises that health care is a provincial responsibility and leaves considerable flexibility to the provinces in the administration of their individual health care plans. While the criteria of public administration, universality and portability are reasonably clear in the Act, the criteria of comprehensiveness and accessibility, both in terms of reasonable access and reasonable compensation, are much more open to interpretation and this directly affects the circumstances under which the Department would determine that these criteria have not been met and the situations that would constitute contraventions of the Canada Health Act.

3. The Directorate essentially operates under the general guidelines outlined in a letter from the Minister to his provincial colleagues in 1985. The letter emphasised flexibility in the interpretation of the Act and the overall tone was one of minimal intervention in provincial jurisdiction. The Directorate also uses the Policy Interpretation manual developed in 1984. There are regulations concerning the provision of information, by the provinces, on user charges and extra-billing but no regulations concerning the provision of other information by the provinces. The Act prescribes a process to impose discretionary penalties in cases of non compliance but this section of the Act has never been invoked. The preference has clearly been to deal with issues, even in cases of possible non compliance, through persuasion and discussion.

   This situation affects the ability of the Directorate to investigate or conduct in-depth analysis of potential compliance issues and the Directorate often has to rely on information provided by the provinces or on the "lack of evidence" that a given issue may indicate a contravention to the Act. There are issues, for example waiting lists or bed closures, which may not technically contravene

provisions of the CHA but nonetheless may threaten the underlying principles of the CHA. The Directorate could be in a better position to reassure the members of Parliament or the Canadian public that criteria are being met if it could use a greater variety of sources of information.

4. So far, provincial plans have largely met the requirements of the Act and there appears to have been few cases of non compliance. However, faced with increasing health care cost, provinces are considering reforms which may put into question the traditional interpretation of the criteria. In this context it will become more and more critical to define the "boundaries" of the criteria or the extent of provincial flexibility under the Act. The current method of monitoring may have to change to reflect the evolution of the Health Care System.

5. There is a need to monitor the status of the health care system as a whole, including the implications of emerging issues for the underlying principles of the Canada Health Act. The Directorate has recognized this need and, in the last few years, has been expanding the breath of it monitoring.

EVALUATION OF

HEALTH INSURANCE MONITORING

Program Evaluation Division
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INTRODUCTION

Purpose

The Canada Health Act (1984) establishes criteria and conditions for federal contributions to the provinces and territories in support of insured health services and certain extended health care services.

The responsibility for monitoring and assessing whether the provincial programs meet the criteria and conditions as specified in the Act rests with Health and Welfare Canada, more specifically with the Health Insurance Directorate, Health Services and Promotion Branch.

Following discussions about the issues that should be addressed in an evaluation of the Health Insurance program, the ADM, Health Services and Promotion Branch, the Director General, Health Insurance Directorate, and the Director General, Program Audit and Review Directorate agreed that the evaluation would focus on the effectiveness of the Health Insurance Directorate in monitoring provincial programs and in assessing compliance with the criteria and conditions specified in the Act. The effectiveness of the Health Insurance Directorate in this regard was raised by Directorate officials as an issue for evaluation purposes.

The Evaluation Issue

The purpose of this project was to address the following question: "Has the role of Health Insurance in monitoring and assessment been effective?

The study addressed this question by looking at the following:

1. Clarity of criteria and conditions as a basis for monitoring;
2. Evidence that reasonable procedures exist to monitor and assess compliance with criteria/conditions;
3. Evidence that criteria and conditions are consistently applied to assess compliance;
4. Evidence that procedures are effectively applied to identify issues of concern and to assess compliance with criteria/conditions;
5. Evidence that "appropriate" action has been taken to communicate information to senior departmental officials.

Methodology

The study was limited to a review of relevant material either from the literature, federal and provincial publicly available documents, internal documents and files and of interviews within Health and Welfare Canada officials. Provinces and national health organizations (with the exception of the Canadian Nurses Association) were not consulted.

Evaluation Team

The project was conducted by the Program Evaluation Division with the assistance of an outside consultant and in cooperation with the Health Insurance Directorate.

Organization of the Report

The report is comprised of three chapters:

Chapter I describes the interpretation of the criteria and conditions of the Canada Health Act by the Department.

Chapter II discusses issues related to the interpretations of the criteria and conditions of the Canada Health Act.

Chapter III describes and assesses the adequacy of the procedures used by the Health Insurance Directorate in addressing these issues, giving consideration to the environment in which the Directorate operates.

CHAPTER ONE

THE CANADA HEALTH ACT CRITERIA

Background

The Canada Health Act (CHA) came into effect in 1984. It replaced the Medical Care Act (1966) and the Hospital Insurance and Diagnostic Services Act (1957) but for the most part incorporated the provisions of these Acts.

The Canada Health Act was intended to ensure the continuance and maintenance of the national standards or the five criteria on which the Canadian health care system is built. These criteria are:

(a) Public Administration;
(b) Comprehensiveness;
(c) Universality;
(d) Portability; and
(e) Accessibility.

The Act also defines two conditions under which financial transfers to the provinces are to be made. These are the provision of information to the Minister, and recognition of the federal contribution to health care.

Under the Act, provinces are subject to financial penalties, through partial withholding of cash payments, if they do not meet these criteria and conditions, or where a province has permitted payment for insured services subject to user fees[1] in hospitals or extra billing[2] by physicians. User fees and extra billing were viewed by many in the health care field as limiting (or potentially limiting) universal access to health care and therefore threatening the basic principles of universality and accessibility in the Canadian health care system.[3]

The purpose of this chapter is to describe the interpretation of the criteria and conditions of the Canada Health Act by Health and Welfare Canada.

Departmental Interpretation of the Criteria

The Department bases its interpretation of the criteria and conditions outlined in the Act on a number of sources. These include the definitions as outlined in the Act itself, a 1985 Letter to all provinces from the

Minister of National Health and Welfare of the day the Honourable Jake Epp, and a policy manual prepared in 1984 by the Policy, Planning and Information Branch, National Health and Welfare. Whenever issues arise, legal opinions with respect to provisions of the Act are often obtained to assist in interpretations.

The Minister's 1985 letter sets out the principles which guide the administration of the CHA. These include:

- recognition of **provincial jurisdiction** in the areas of health and the delivery of health services;
- provision of **flexibility** for the provinces in operating and administering their health care plans; and,
- the use of **cooperation and collaborative partnership** in administering the provisions of the Act. Specifically, the federal government informed the provinces that it would not use the regulatory process in ensuring compliance with the Act "unless absolutely necessary".

Following is the Department's interpretation of the criteria as outlined in the Canada Health Act[4].

Public Administration

Provincial health insurance plans must be administered and operated on a public and non-profit basis. (Ref. Section 8, Canada Health Act)

Provincial plans must be administered and operated by a public authority appointed or designated by the province. The Act permits the use of different structures in the administration of provincial plans however, the principles of "public administration" and "non profit" must be respected.[5]

The public authority is accountable to the provincial government. It is subject to audit by the authority legally responsible for the audit of provincial accounts. Audits of the plan's records and accounts are public. They must be carried out according to provincial auditing standards and accounting requirements.

Provincial plans must be administered on a non profit basis. That is, the organization, commission or agency administering the plan cannot record a profit on its operations.

The public authority can transfer or delegate, responsibility for collecting revenues (eg. premiums) or making payments for insured health services (eg. paying doctors) to another agency. However, the amounts paid out

for insured health services are determined by the public authority. In turn, the public authority is accountable to the province for decisions on benefit levels and services. As well, the administering agency accounts are subject to assessment and approval by the public authority. In keeping with the principle of non profit administration, the agency cannot report more revenues collected than benefits paid out.

While the plan must be administered on a non profit basis, the Act does allow "for profit" or proprietary hospitals. It also allows profit making operations within hospitals (eg. snack bars) and allows hospitals to run a surplus. It recognizes that medical practitioners are private business people and they too can make a profit. Private sector involvement in the management of hospitals is allowed provided that the provincial authority has responsibility for decisions about benefit coverage and levels.[6]

Private insurance plans play a residual role in the coverage of health services. That is, they cannot cover "medically required" hospital and physician services, but can provide coverage for such extras as private and semi-private accommodation and other services which are not "medically required".

Comprehensiveness

Provincial plans must insure all medically required hospital and physician services. (Ref. Section 9, Canada Health Act)

The Canada Health Act and its criteria apply to "medically required" physician services, "medically necessary" hospital services and surgical-dental services which require a hospital for their performance. Extended health care services (i.e. nursing home intermediate care and adult residential care services, nursing home care and ambulatory health care services) are subject to the conditions but not the criteria of the Act.

Determining what is "medically necessary" is the "prerogative and responsibility" of the provinces and the medical profession. What is "medically necessary" and therefore what is covered under the provincial plan is open to interpretation and may be defined differently depending on the circumstances (ie. a procedure appropriate for one patient may be inappropriate for another). As well, the provinces and the medical profession have some flexibility in determining what is or is not covered by the plan. For example, injectable drugs in physicians' offices may be considered as "not included" under the plan and could be subject to charges, while provision of the injection itself would be part of the insured service. Only "medically necessary" insured services are subject to the criteria of universality, portability and accessibility.

"Physician services" covered are "medically required" services provided by licensed medical practitioners where these are performed (hospital,

clinic, physician's office) and surgical-dental procedures requiring a hospital for their proper performance. Provinces determine who is a "licensed medical practitioner" under the Act. (For example, some provinces licence or certify osteopaths to perform medical acts while other do not). In general, the Department interprets the concept of medical practitioner as "any health professional licensed to practice medicine in a province by an authorizing agency (usually the provincial colleges of physicians and surgeons)".

Hospital services covered include both in and out patient acute, rehabilitative or chronic care. Previously (under Hospital Insurance and Diagnostic Services Act), hospital services were defined in terms of the type or portion of facility and now these services are defined in terms of the type of care. The provinces determine which hospitals and services are required for acute, rehabilitation or chronic care. Insured hospital services include in-patient care at the standard ward level, medically necessary private or semi private accommodation, nursing services and other services provided by persons who receive remuneration from the hospital, necessary drugs, biologicals, supplies and diagnostic services, and a range of out patient services.

What constitutes "acute" and "rehabilitation" care appear to be generally recognized[7]. With respect to "chronic care" the Department uses two criteria in determining what aspects of chronic care are covered under the Act. These are "medical necessity", and whether or not a patient is more or less permanently resident in a health care institution. That is, where a patient is more or less permanently resident, meals and accommodation need not be insured and the patient may be charged for these services.

Specifically excluded from the definition of hospital services and therefore not subject to the criteria of the Act are those services provided by facilities for the mentally ill[8], nursing home intermediate care and adult residential care services.

Coverage of "other health care practitioners" under provincial plans is at the discretion of the provinces. Reference to "other health care practitioners" was made in the Act in order to recognize that the concept is broader than just physicians and dentist. It was not intended as a means to expand the range of nationally insured health services. Where provinces have chosen to cover services provided by "other health care practitioners" (other than those providing medically necessary hospital services), these are not subject to the criteria of the Act.

In general, all provinces cover more than what is required by federal legislation. Only what is required by federal legislation is subject to the basic principles of the Canada Health Act.

Universality

All provincial residents (100%) must be entitled to insured services on uniform terms and conditions. (Ref. Section 10, Canada Health Act)

The concept of universality deals with entitlement. It is intended to ensure that all "bona fide" residents of a province are entitled to coverage under one of the 12 provincial/territorial health plans. As noted, coverage is for all "medically necessary" hospital and physician services and dental services requiring a hospital for their proper performance.

The concept of "resident" is defined in the Act as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province". A "resident" does not include a tourist, a transient or a visitor to the province". A province may require a minimum period of residence or waiting period, not exceeding three months, for a person to establish eligibility for, or entitlement to, insured health services. The concept of "resident" is further defined in the Agreement on Eligibility and Portability" which was developed through collaborative (federal/provincial) efforts.

There are some groups that are specifically excluded from coverage under the Canada Health Act (ie. armed services personnel, members of the RCMP, penitentiary inmates) but are covered under other federal legislation. In addition, eligible residents can decide not to participate in the provincial plan.

The concept of "uniform terms and conditions" is to ensure there is no discrimination (with respect to entitlement) against any population group for whatever reason, be it income, age, health status or other reason.

Provinces have the constitutional right to levy taxes to assist in financing their health care systems. Therefore, provinces can require the payment of premiums in respect of insured health services. However premiums cannot preclude eligible residents from insured services should they be unable to pay the premium.

Where "residents of Canada have been unable to obtain coverage or have lost coverage through no fault of their own", the Health Insurance Supplementary Fund (not part of the Canada Health Act) may provide for payment of claims for insured health services.[9]

Accessibility

Provincial plans must provide for reasonable access to insured services on uniform terms and conditions and without financial or other barriers. Provinces must also provide reasonable compensation to physicians and dentists for all insured health services rendered. As

well, provinces must make payments to hospitals for the cost of insured health services. (Ref. Sec.12, Canada Health Act)

Reasonable Access:

The provisions of the Act and the departmental interpretation of "reasonable access" have been clearly articulated in the case of financial access to insured health services. The criterion of accessibility is aimed at discouraging point of services charges, including user charges or extra billing, for insured health services to insured persons. It is also aimed at discouraging other financial barriers such as taxes tied to the amount of health services actually or potentially consumed by an individual. Provinces are subject to dollar-for-dollar financial penalties where extra billing or user charges for insured hospital or physician services are permitted, or where there are direct links between consumption and payment.

Charges are permitted for uninsured services (eg. completion of medical certificates for school attendance where the service is not insured), and for services which are not considered "medically necessary" (eg. accommodation and/or meals for persons receiving chronic care who are more or less permanently resident in an institution).[10]

With respect to physical or geographic access to insured health services, or access to the services of medical specialists, in general, the Department bases its decisions on the principle of "where and as available"[11]. That is, access has been interpreted to mean access "where services are provided".[12] Constitutional realities are such that provinces decide where to locate hospitals and hospital services, and what resources will be allocated to services in different locations. Resource allocation and health service priorities are a provincial prerogative. As well, the licensing, supply and distribution of health manpower fall within provincial jurisdiction.[13] While physicians have the right to locate where they want, provinces can (and some do) provide incentives to physicians who choose to locate in less serviced areas.

The Department also recognizes that there may be situations where the demand for elective surgery and the capacity of institutions or medical practitioners to provide the service results in waiting lists. Waiting lists for elective surgery have not in the past been considered a contravention of the Act.

Uniform Terms and Conditions:

The Act is also aimed at preventing discrimination (at the point of service, or later) based on such factors as income, age, health status or health risk

which could limit access to insured health services. That is, insured health services must be provided to all eligible residents on "uniform terms and conditions".

Reasonable Compensation:

"Reasonable compensation" must be provided to physicians and hospitals for insured health services. "Reasonable compensation" is intended to ensure that providers will provide the services without charge to patients. The Department considers compensation "reasonable" when payments are made in accordance with a provincially authorized tariff or system of payment.

Determining what is "reasonable compensation" is essentially the prerogative of the provincial government working "in partnership" with providers. Where the partnership approach fails, the Act suggests two options (conciliation or binding arbitration) for resolving compensation disputes which can be used at the discretion of the organizations representing the medical or dental professions. While the Act suggests only two options to resolve disputes, it does not preclude the use of other mechanisms. The Act does not imply "intention on the part of the federal government to act as a budget or fee schedule appeal board in respect of reasonable compensation provisions."[14]

As per Section 12(2) of the Canada Health Act, a province is "deemed" to be in compliance with the Act if it has an agreement with its medical practitioners and dentists that provides negotiations relating to compensation, and for the settlement of disputes. The absence of such an agreement however, does not necessarily constitute a contravention of the Act. Should this agreement not be in place, the Department would be required to determine what would constitute reasonable compensation.

The methods of compensation are determined by the province. Most physicians are currently paid on a fee-for-service basis. However, other types of payment systems such as salary, capitation or sessional fees can be authorized.

Portability

Provincial plans must make payments for cost of medically necessary hospital and physician services received by residents outside the province. (Ref. Sec 11, Canada Health Act)

The portability provision of the Act gives the Canadian health care system its "national" character. Portability is what binds the system together. Without it, there would be 12 independent provincial/territorial health care systems. Within this context, it is a provincial prerogative to

determine and provide the coverage for services rendered in another province.[15]

The portability provision is intended to ensure:

- that insured Canadian residents continue to be covered when temporarily absent from their province of residence, or when moving from one province to another;
- there is a reasonable level of payment to providers for services to out-of-province residents;
- that insured Canadian residents are reasonably reimbursed for necessary emergency hospital or physician services while outside Canada, or for referred services not available in a province or a neighbouring province.

Within Canada:

Provinces are required by the Act to make payments for "medically necessary" hospital and physician services provided to patients who are temporarily absent from their province of residence. Payments in this regard are to be made at "host" provinces rates, that is, for physician services, the provincial plan rate, and for hospital services, the average standard ward per diem cost of the institution providing the service. Other than "host" province rates may be paid where there is an agreement between provinces to do so.

Change of Residence:

For those moving to another province, the Act ensures that residents are covered for insured health services during any minimum waiting period imposed by the new province. It also requires the home province to maintain coverage during the waiting period. The waiting period can be no longer than three months.

Outside Canada:

For insured health services received outside Canada, the Act requires that these be paid at "home" province rates for "similar services".

For services not available in Canada, provinces may decide to pay the full cost of the services rendered. The Departmental Policy Interpretation Manual states that "Canadians should expect to recoup 95 to 100% of

direct costs (excluding transportation and accommodation expenses outside a hospital) for services not available in Canada".[16]

Elective Procedures:

The Act also provides for provincial control over elective non emergency procedures which patients actively seek outside their home province, where these services are provided on a substantially similar basis within the home province. That is, provinces can require that insured residents receive prior consent for such elective services and their payment where they are provided in another province or another country.

Interprovincial Agreements:

There are interprovincial Agreements which facilitate and guide the implementation of the portability provisions. The Agreement on Eligibility and Portability, Hospital and Medical Care Insurances provides "minimum standards" for the interpretation of the portability provisions. It provides greater detail in defining such terms as "resident", "temporarily absent" and circumstances under which interprovincial coverage will be provided. An Inter-Provincial Agreement for the Reciprocal Processing of Out-of-Province Hospital In-patient Claims provides for the processing of out-of-province claims for hospital services. The Department views both of these agreements as meeting the provisions of the Canada Health Act.

All provinces, except Quebec, have entered agreements on the reciprocal billing of medical claims at "host" province rates. Quebec has an agreement with Ontario for medical treatment and payment for services to Quebec residents in the Outaouais and Abitibi regions since 1989. Quebec has agreed to pay Ottawa area physicians host province rates when:

. an Outaouais resident requires emergency medical care while in the Ottawa area; or
. an Outaouais physician refers a patient to an Ottawa physician because the services are not available in the Outaouais.

Otherwise, Quebec reimburses out-of-province physicians at Quebec rates.

Information and Federal Recognition

Two conditions of the Canada Health Act include the provision of information and recognition of federal contributions. The Department interprets these as follows:

The Department of National Health and Welfare is responsible for administering the Canada Health Act and for reporting to Parliament on the administration and operation of the Act including the extent to which the provincial plans have satisfied the criteria and conditions of the Act. Information from the provinces is required to carry out this responsibility. Provinces are required by regulation to annually provide estimates and statements on extra-billing and user charges. As well, they are requested, on a voluntary basis, to provide an annual statement, in the form of a letter to the Minister, "to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operation as they relate to the criteria and conditions of the Canada Health Act"[17]. Where potential compliance issues are brought to the attention of the Department, further information may be requested by mail or telephone directly from the province(s) concerned.

Regarding federal recognition, the Department has used a voluntary approach to encourage provinces to recognized publicly that "the federal, provincial and territorial Ministers of Health are working together in the interests of the taxpayer and patient".

Compliance Provisions and Federal Power to Enforce Provisions of the Act

There are two types of penalties outlined in the Canada Health Act to assist in assuring provincial compliance with the Act's criteria and conditions. These have been described as "automatic penalties" and "discretionary penalties".

Automatic Penalties

The Act contains specific penalty provisions for extra billing and user charges to insured persons for insured services. That is, such patient charges are subject to dollar-for-dollar deductions. Automatic penalties have in fact been successfully used in the past to discourage patient charges.

Discretionary Penalties

The Act describes "discretionary" penalties for violation of the five criteria and the two conditions of the Act and a process for issue resolution. The process is based on federal/provincial consultation, fact finding by the Department, and as a final step, the Governor in Council would be asked to take action. It is intended that financial penalties match the severity of the non compliant situation. The discretionary penalties provision have never been used.

Federal Powers

The provinces have the constitutional responsibility for health and health services. Federal powers in the health field are directly linked to federal spending powers. Penalties as outlined in the Act are consistent with these federal powers.

CHAPTER TWO

CHA INTERPRETATIONS - AN ANALYTICAL REVIEW

Introduction

In recent years the federal government has often been the object of criticisms in the media, the literature and by various organizations with respect to the health care system. The criticisms often seem to imply a failure to enforce the criteria and the conditions of the Canada Health Act. Decisions made by provincial health plans are often perceived by the general public as cases of non-compliance to the Act.

The purpose of this chapter is to review these criticisms and to discuss the issues surrounding the criteria and conditions of the Act. Most of these issues are very complex and it is beyond the scope of this study to solve them or even suggest solutions. Rather, the purpose is to provide the reader with an understanding of the issues involved and the context in which the Health Insurance Directorate operates.

In addressing these issues, the evaluation draws from views expressed by commentators in the literature, government Task Forces, health organizations and internal documents. The issues raised are also examined in light of the past and present interpretations of the criteria and conditions of the Act.

The Information Sources

The review was based on several sources. Firstly, a review of the literature was undertaken through computer searches at the University of Ottawa's Health Science Library and at the Health and Welfare Library. These computer searches were supplemented by manual search of the indexes (largely starting in 1985) of several key journals such as the Canadian Journal of Public Health, the Canadian Medical Association Journal, the Canadian Nurse, etc. The purpose was to find out what commentators had to say about the criteria and conditions of the Act, their monitoring and the degree of compliance of the health care system with them. Secondly, the review included documents prepared by various organizations and Task Forces as well as documents prepared for or by the Health Action Lobby (HEAL)[18] and those prepared by the Health Insurance Directorate in response to HEAL. HEAL's views were considered important since this organization represents the largest national

health organizations in Canada as well as the Consumer's Association of Canada. The purpose was not to discuss the validity of the views expressed but to illustrate the type of issues the Directorate is facing in interpreting and monitoring the criteria and conditions of the Act. It was hoped that the review of these documents would help identify the areas of possible difficulty, either actual or potential.

Generally the material found in the literature reviewed is relevant to the performance of the federal government as a whole and very little directly addresses the performance of the Directorate as such. First there are the descriptions of the Canadian health care system from which inferences can be drawn about access, comprehensiveness, etc. Second, is argumentation about deficiencies in the system and the degree to which they can be attributed to weaknesses in the Act itself or in its administration by the federal government. Very little is found about the extent to which any perceived weaknesses in the administration of the Act can be attributed to the Directorate.

Public Administration

Even though provincial plans are organized and administered differently, they all appear to meet the requirements of the Act to everyone's satisfaction. No comments were found in the literature and documents reviewed about the performance of the federal government in the administration of the "public administration" provision of the Act.

Comprehensiveness

Under this criterion, the Act requires that provincial insurance plans provide coverage for (i) "hospital services" which are "medically necessary", (ii) "medically required services" provided by physicians, and (iii) "surgical dental services" which are "medically or dentally required" and which are in fact performed in, and can be properly performed only in, a hospital. The Act lists several "hospital services" which may be provided to both in-patients and out-patients for the purpose of "maintaining health, preventing diseases or diagnosis or treating an injury, illness or disability; these include nursing services, accommodation, diagnostic facilities such as laboratories, etc.

The issue about comprehensiveness seems to be about the definition of medically necessary services and who is to define them. According to Martin[19], the Act's definition of comprehensiveness can be interpreted in two ways. One is that the term "insured health services" has "no normative content", but simply refers to the collection of those health services which a given province has chosen to cover. This interpretation, she says, "tends to make nonsense of...the Act" because there would be automatic compliance. The other interpretation is that "comprehensiveness" requires the provision of a minimal level of health services by every province. However, this level of health services is not

defined. The Act speaks only of services which are "medically necessary".

The Minister's 1985 letter says that "...provinces, along with the medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary." If it is left to the provincial governments to decide what is medically necessary, then there would be automatic compliance and there would be no need for monitoring. If it is left to the medical profession to decide, then it would be necessary to ensure that whatever doctors decide is in fact insured. The Minister's letter seems to imply an agreement between provinces and medical professionals. It is not clear under what circumstances a provincial plan would be in non compliance with the Act.

So far, there have not been serious conflicts over comprehensiveness between provincial governments and patients or doctors. The only issue that came up recently was about the payment by provincial plans for abortions performed outside a hospital e.g., in a private clinic. The federal position is that "medically necessary" abortions should be covered under the provincial plans. In cases of abortions performed outside hospitals, the provincial plan should cover the physician portion of the cost. It is up to the province to decide on the medical necessity.

Although the literature refers significantly to the interpretation of comprehensiveness, it says very little about the related federal monitoring and compliance functions. HEAL refers to "medical necessity" as a concept that needs clarification[20] but does not elaborate. It has been proposed that the establishment of clinical guidelines, acceptable to the medical profession, could form the basis for determining what physician services are medically necessary under what circumstances. This kind of selective approach is considered as having considerable potential for controlling costs.[21] Given the current concern about controlling health care costs, this issue may increasingly become important in the future and may even become a source of conflict if, as suggested in one of HEAL's papers, "provincial governments try to move the right to define insured services from physicians to governments".[22]

Universality

The provincial insurance plan must provide coverage on uniform terms and conditions to all residents of the province other than members of the armed services and the RCMP, penitentiary inmates, and people who have moved to the province within the preceding three month period.

As of January 1992, the only examples of possible non-compliance were found in PEI, whose coverage was "linked to" the provision of a Social Insurance Number, and in British Columbia, whose coverage was conditional on the payment of premiums. British Columbia was not

paying physicians who treated uninsured people. The case of PEI is still under discussion. Currently, British Columbia has decided that no one will be denied services; the provincial plan will pay the physician but try to recover the cost from the uninsured patients afterwards.

Health and Welfare Canada does not preclude premiums as long as an "inability" to pay them does not result in the denial of coverage. The Minister's letter does not deal with how the inability is to be determined and whether it is meant to encompass an unwillingness to pay. Another issue is the fact that provincial residents may be unaware of the federal requirement that coverage must remain in place regardless of a persons's ability to pay premiums (first paper, HEAL, October, 1991). Thus they may not have objected when told that they were uninsured. Indeed, on the assumption that they were not covered, perhaps residents have refrained from even seeking care. Moreover, provincial governments may not be "...in a hurry to inform ..." residents of their rights. No assertion is made here about any federal responsibility to ensure that residents are properly informed on this matter.

Portability

All provinces have signed agreements for the reciprocal billing of hospital services and, with the exception of Quebec, physicians services. For several years, Quebec refused to pay rates higher than those it pays within its territory for physician services. It now has agreed to pay host province rates to Ontario doctors but only for the residents of the Outaouais and the Abitibi regions in the case of emergency treatment or specialized treatment not available in Quebec.

For hospital services in other countries, British Columbia and Quebec may be paying less than their own rates, and Nova Scotia is paying nothing for out-patient services.

The literature expresses no concerns, direct or indirect, about the federal government's interpretation of portability. It identifies no cases of non-compliance other than those already detected by the Department itself. Only the National Welfare Council criticizes the federal government for not imposing financial penalties on those provinces which, seemingly, are in non-compliance; and even its criticism is restrained in wording and general in application: "The federal government should be more vigilant about safeguarding the five principles...It should not hesitate to use the general penalty provisions of the Canada Health Act as a last resort in resolving matters of principle".

Accessibility

Under the Act, provincial plans must provide for reasonable access to insured services without financial barriers. Provinces must also pay reasonable compensation to physicians and dentists for all insured services rendered.

Financial access. Under the Act, user fees and extra billing are subject to automatic financial penalties. Faced with heavy penalties, provinces that had allowed such practices eliminated them by April 1, 1987. No evidence of current "charges" (extra-billing or user fees) is given in the current literature.

These provisions of the Act may however become under pressure as provinces seek ways to cut health care costs or to raise additional revenue. One example is the Quebec's Green Paper, released in December 1991. It proposed two sets of options for financing basic health services. One set of proposals included salary contributions from employees and self-employed persons; identifying a portion of income taxes solely for financing health and social services; and financing health and social services from the Quebec sales tax. The second set of options linked payment to consumption for those patients who are financially able to pay. For example, treating hospital and medical services as taxable benefits for income tax purposes or charging fees for hospital support services such as meals and accommodation. The first set of proposals would be acceptable under the Act because it preserves the notion of shared risk with no specific link between payment and consumption. The second set however would be similar to user fees and, consequently, in contravention of the Act.

Quebec is also considering the introduction of a "ticket orienteur" to reduce the inappropriate use of emergency departments. The intent is to redirect patients away from emergency departments when treatment is a non-emergency. The position of Health and Welfare Canada is that such a "ticket" would be a user charge under the definition of the Canada Health Act. At the time of writing, however, none of the above proposals from Quebec had been implemented.

Reasonable access. The reasonable access criterion is open to interpretation. Of particular concern is the existence of waiting lists (which could be more appropriately called waiting times). There have been alarmed assertions in the media that waiting lists were growing, that patients were being turned away, in severe pain, unable to work or even dying while on the wait and that rationing was being accepted as the norm.

Waiting lists are typically for specialized treatment (e.g. heart surgery), especially in acute care hospitals. No one seems to question the readiness of access to primary care, not even the Americans who studied the Canadian health care system. "Patients [in Ontario] visit their family physician or other general practitioner with no evidence of .. lengthy waiting times for appointments" (United States General Accounting Office, June 1991).[23] "Canadians have unlimited access to physicians of

their choice...In 1986, Canada had 210 physicians for every 100,000 persons and the United States had 212..."[24] (State of Oregon, 1990).

Some commentators have interpreted waiting lists as government attempts to ration health care in the face of rising health care costs (Jacobs[25], Globerman[26]) while others (Amoko[27], Naylor[28]) argue that waiting lists, because of the way they are compiled and maintained, are not, at the present time, an accurate measure of inaccessibility. The few studies on waiting lists conducted in Canada are inconclusive as to their effect on accessibility but they illustrate basic problems which should be dealt with. For example, most waiting lists are prepared and maintained by individual surgeons without a standard way of compiling, maintaining and managing them.[29] Studies done on waiting lists indicated a large variation among individual patients, periods of waiting as well as among regions[30] and that queues varied considerably by facility.[31]

The general view seems to be that waiting lists should not necessarily be dispensed with but, rather, that their management should be improved. According to Naylor, "the real issue for any health care system dedicated to universal access is not that the queue exist for some services, but rather how best to measure, monitor, and manage them". There have been suggestion that waiting lists should be managed at the regional (or even the provincial) level for optimal resource utilization and specific criteria for proper usage of waiting lists have been proposed.[32] As well, factors that influence waiting lists are not well known and further research is needed in this area.

The federal Interpretation Manual states that "...at certain peak times the capacity limits of a particular institution or a particular practitioner may be reached. Waiting lists for elective surgical procedures may, in consequence, be created. In such cases, federal policy has been to not consider this to be a contravention of the reasonable access requirement". In view of the growing public concern about waiting lists, it is not clear that this description of acceptable waiting list is compatible with what is now being experienced. The Department seems to consider waiting lists an issue of supply and demand which falls within provincial jurisdiction to resolve and that there is no evidence that accessibility is affected. As long as emergency care is provided, waiting lists are not considered to be contraventions. In the absence of reliable data/information, how can the Health Insurance Directorate be assured that existing waiting lists are not affecting accessibility. At what point does HID consider that waiting lists become unacceptable under the Act? Do provincial plans have standards concerning waiting time and are these standards acceptable?
To date, there has been little criticism in the literature of the federal government in this regard. There are general denunciations of waiting

lists as a form of rationing but the attack is directed primarily at the provincial governments.

Reasonable compensation. The intent of the reasonable compensation clause was to ensure that provincial plans would pay physicians at such a rate that the majority of physicians would accept the plan payments as payment in full. Physicians compensation is considered by HID as a matter to be the object of agreement between the physicians and the provincial plans and, consequently, a provincial responsibility. As long as there is such agreement, the physicians are deemed to be "reasonably" compensated. In case of dispute, the method of settlement is also considered a matter of provincial responsibility. The conciliation and arbitration mechanisms mentioned in the Act are interpreted as being only options.

In the case of "capping" of payments to physicians by several provinces, the Health Insurance Directorate considers that "capping, per se, is not a problem unless it leads to impeded access". That the Directorate has considered "impeded access" to mean more than financial access is evidenced by the following: "Of concern under CHA is that capping risks reduction in patients' reasonable access to insured health services ie. doctors may ration their services to stay within payment ceilings or reduce service once the cap is reached." The Directorate has also noted that to date, it has no evidence that this is happening. In the absence of a clear interpretation of the circumstances under which impeded access would occur, it is not clear what "evidence" would indicate its existence.

In cases where disputes resulted in withdrawal of services by medical practitioners (strikes), the position of Health and Welfare Canada has been one of non intervention as long as the striking actions did not impede access, i.e., as long as emergency care was provided.[33] As physician compensation was considered a provincial responsibility, these incidents were not seen as constituting contraventions of the CHA.[34] Again, the absence of "evidence" to the contrary appears to be the basis for assessing the situation.

Geographical access. With respect to geographical access, HID interpretation is that provinces determine the supply and distribution of health services and manpower as well as the allocation of health care resources. The federal government cannot direct a province as to where services should be located. The Department interprets the provisions as reasonable access to services "where and as available".

Program Information

In order to qualify for a full federal contribution, each provincial government must provide the Minister with such information "as the

Minister may reasonably require for the purpose of this Act" and the Act authorizes the Minister to make regulations to that effect.

The only regulations promulgated to date concerned the provision of information on extra-billing and user charges. Before the passage of the Canada Health Act, draft regulations on information requirements were proposed to the provinces but they refused to accept them on the ground that the information required was too detailed, not essential to them and that it would be too costly to collect it. There has been no further attempt to develop regulations.

The Minister's 1985 letter asks only for "estimates and statements on extra-billing and user charges" and for "an annual statement" from each province describing the operations of its assurance plan "as they relate to the criteria and conditions of the Act". There is no other information formally required from the provinces and the information actually received is essentially descriptive of the provincial plans.

There has been criticism about the federal information gathering and reporting activities. The Auditor General (1990) has stated that none of the annual Reports to Parliament contains conclusions on the extent to which each province has satisfied the criteria and conditions. In his view, such conclusions are necessary to meet the requirements of the Act. Others consider that the information provided is insufficient (Senate Committee) and that the federal government has too much discretion in the acquisition and the use of information (HEAL). No elaboration was provided however on what more information was needed.

Federal Recognition

The subject of federal recognition has not been encountered in the literature and this is not a condition that the Health Directorate monitors actively. The 1985 Minister's letter does not provide any specific guideline on this condition.

Conclusions

The purpose of this chapter was to discuss some of the issues and difficulties surrounding the administration of the Canada Health Act.

1. The literature and other documents reviewed for this study failed to turn out any non compliance case that the Directorate is not aware of. On the basis of the file review and of the literature search, it can be concluded that the criteria, as interpreted by the Department, have largely been met. There is no challenge in the literature to this general conclusion.

2. The criteria of public administration, universality, portability are reasonably clear in the Act. The difficulties are with the definition of the terms "comprehensiveness" and "accessibility" both in terms

of reasonable access (as this relates to waiting lists) and reasonable compensation. Current interpretations do not define a point at which the federal government would consider non compliance to exist.

3. At least since 1985, the preference in dealing with issues has clearly been one of minimal intervention in what is considered provincial responsibility.

CHAPTER THREE

EFFECTIVENESS IN MONITORING COMPLIANCE

The primary role of the Health Insurance Directorate(HID) is to monitor, assess and advise the Minister on the compatibility of provincial and territorial health care insurance plans with the Canada Health Act. The purpose of this chapter is to describe how the Directorate fulfils its role and to assess the extent to which it does it effectively.

The Monitoring Process

Through its monitoring process, the Health Insurance Directorate identifies and assesses events or situations within the health care system which have potential or actual implications for administration of the Canada Health Act(CHA). The process consists of an "early warning" system through the continuous monitoring of news clippings and media reports, correspondence from the public and trade papers (Program Administration Division).[35] The process also provides for more in-depth analysis of issues identified through the media, and for ongoing monitoring of provincial legislation and analysis of developments and events related to health care delivery within the provinces (Program Analysis Division). In this regard, HID reviews and analyzes provincial annual reports, information provided by provinces to the Directorate on their health plans, provincial auditor general reports, policy and budget papers, and task force reports[36]. HID is also in contact with and monitors the work of other federal Departments as it affects eligibility and entitlement for such groups as native canadians, immigrants, refugees and penitentiary inmates.

The Directorate is also apprised of concerns about provincial compliance with criteria through direct enquiries and requests for Departmental interpretations or action. Requests have come from provinces, professional associations, individual practitioners and members of the general public seeking action on a particular issue, or the Directorate's advice about consistency with the CHA criteria of policies or initiatives they are considering prior to their implementation.[37]

When a potential problem is identified eg. from consumer complaints, media reports or other sources, the Directorate assesses the issue against the CHA criteria and precedents. If non compliance is suspected, the

Directorate will seek additional information or clarification from the province(s) concerned in order to complete its assessment. Departmental Legal Services and the Policy Planning and Information Branch of the Department are also consulted on selected issues. In particular, Legal Services will be consulted where there is suspected non compliance in order to obtain a legal opinion.

The File Review

The Health Insurance Directorate maintains its files using a "desk top imaging" system. That is, actual files are stored in a computer and can easily be accessed with the use of a file index and screen. The system provides a means of storing and accessing files efficiently. The system currently contains 1076 files and over 4,000 pages of information. It contains HID files since 1987. Files for the years 1984 to 1986 are still maintained in file cabinets. Files are classified or indexed according to an number of variables (eg. by year, province, CHA criterion, selected issues, Departmental officials informed, nature of information etc.) and are cross referenced where appropriate.

The system contains not only information with respect to CHA issues identified by Health Insurance, but also, for example, such documents as speech notes for the Minister, briefings for appearances before committees or meetings with provincial officials or professional associations as well as other types of information.

In view of the large volume of files, it was not possible to systematically review all the files. Instead, the review focused on files related to the accessibility criterion including "reasonable access" and "reasonable compensation" (issues regarding negotiations or disputes). The reason for choosing accessibility is that it is the area that appears to raise the most concern in the literature and the media. All the files related to accessibility for the years 1987 (to obtain an historical perspective on the monitoring function), 1991 and 1992 (for currency) were reviewed. In addition, all the files for 1992 pertaining to the five criteria were reviewed. Altogether, 139 files were examined.

The purpose of the file review was to assess the effectiveness of the Directorate's monitoring and assessment against the following criteria:

1. the existence, and the use of, procedures to identify and assess issues related to provincial compliance with the criteria and conditions of the Canada Health Act;

2. evidence of actual identification and assessment of issues related to provincial compliance;

3. the consistency of the Directorate's positions and advice with the Departmental interpretations of the criteria as described in Chapter I; and

4. the consistency with which the Directorate has applied the criteria to similar issues across the country;

5. evidence that information about provincial compliance is communicated to senior Departmental officials and to the Minister;

Directorate's Assessment of Issues

The file review showed that every event, situation, issue or concern identified was assessed by the Health Insurance Directorate against the CHA criteria as discussed in Chapter 1. Assessments are based on information received and past experience with similar issues. Where appropriate, additional information is requested from the provinces. The assessment of issues against the CHA criteria appears to be an integral part of the monitoring process.

The majority (90%) of issues examined were assessed NOT to be compliance issues and consequently were not considered contraventions of the Canada Health Act. Many issues examined by HID were outside the scope of the CHA, for example, those relating to "additional services" (eg. community dental care, eyeglasses, non medically necessary services which provinces may have chosen to insure, the work of other health practitioners, not physicians or dentists, outside a hospital setting). Still, other issues fall within provincial jurisdiction (eg. those relating to the supply and distribution of health care resources). Others were considered administrative or efficiency issues and not issues of compliance (eg. waiting lists, closure of hospital beds). The nature of the issues identified is summarized in Table I.

The Directorate also examined proposed or potential changes in provincial health plans (eg. province considering user fees, province considering deinsuring abortion services). That HID identifies and assesses proposed initiatives indicates that the Directorate is to some extent anticipatory in its monitoring activities.

Over the years there have been relatively few compliance issues. For these issues which have been identified as possible compliance concerns, the files indicate that the Health Insurance Directorate has undertaken efforts on a cooperative basis within the Department (ie.in consultation with Legal Services and PPIB) and with the provinces (ie. through correspondence, meetings with provincial officials and through discussions within the federal/provincial Advisory Committee on

Institutional and Medical Services) to assist in finding solutions to existing concerns.

TABLE I Nature of Issues/Events Identified by the Health Insurance Directorate, Reasonable Access Criterion, 1987, 1991, 1992.

Nature of Issue	1987	1991	1992
Proposed Changes In provincial Health Plans	2	2	1
Event which may/may not result in changes to provincial plan	-	1	2
Issues/event/changes outside CHA	3	-	-
HID continuing to monitor situation/collect more info.	2	1	2
Events/situations assessed as "Not contravening CHA"	13	4	2
Issues identified as concerns	2	-	1
Unable to classify	3	2	-
TOTAL	25	10	8

Note: There were 64 files reviewed but there were, in some cases, more than one file relating to the same issue.

The current compliance issues (which the Directorate identifies as "issues of concern") are:

Abortion: Refusal to pay for physician services for abortion provided outside hospitals (Newfoundland, Nova Scotia, Manitoba, Prince Edward Island).

In Canada portability: Refusal by Quebec to pay host province rates for physician services received by Quebec residents in other provinces.

Out of Canada portability: Payment for hospital services may be less than home province rates (British Columbia, Quebec) or deinsuring outpatient hospital services outside Canada (Nova Scotia).

Social Insurance Number: Health insurance coverage linked to providing Social Insurance Number (Prince Edward Island).

Premiums: Health insurance coverage linked to the payment of premiums (British Columbia).

Reasonable compensation: British Columbia physicians not compensated when treating patients who have not paid premiums.

The Directorate is continuing discussions with the provinces concerned to resolve these issues.

Consistency of Application of the Criteria

In order to assess the consistency of the monitoring process with respect to all CHA criteria, all the 1992 files were reviewed within the categories of universality, portability, public administration and comprehensiveness and related issues categories, specifically deinsurance of previously insured services and direct charges.

On the basis of the files reviewed, the application of criteria by HID to individual issues has been consistent with ministerial policies and departmental interpretations as set out in Chapter 1.

The Health Insurance Directorate has consistently maintained the following positions:

- firm and consistent opposition to user fees or extra billing for insured services;
- user charges are permitted for uninsured services;
- residency is the sole criterion for eligibility to insured services;
- payments for out of province medically necessary services should be at the "host" province rates;
- geographic and physical access to services and specialists "where and as available" (the federal government does not tell the provinces where to locate the services or how they should be made available);
- health care delivery and the supply and distribution of health care resources including manpower is within provincial jurisdiction.
- fee negotiations and payment to physicians is a provincial responsibility.

- reasonable compensation is one aspect of "accessibility". The rationale is that reasonably compensated health care professionals will not impose direct patient charges or other impediments to access.

- how a province provides for the settlement of fee disputes is a matter to be decided between the province and the organization representing the medical profession. The CHA does not empower the Minister (of National Health and Welfare) to impose binding arbitration on a province and territory.

- the CHA was never intended as an arbiter between a provincial government and its doctors.

These positions reflect the Department's interpretation of the criteria and also the principles outlined in the 1985 Letter from the Minister of NHW to the provinces which stressed flexibility for provinces to administer their plans and recognised the provincial jurisdiction in matters of health.

Communication of Information to Senior Officials

Information reviewed for this study also confirmed that HID systematically informed Senior Departmental officials about events and issues related to the administration of the CHA and advised them as to Departmental positions with respect to these events or issues.

All issues, events or concerns which were examined by the Health Insurance Directorate and which were on file, whether compliance concerns or not, were communicated to senior Departmental officials and/or to the Minister of National Health and Welfare. Many issues were communicated several times either because they were identified from different sources, or because there was additional information to report with respect to a particular issue. Typically, the information communicated to the Minister includes a description of the issue or event, background details concerning the event, the HID assessment against the CHA criteria with a position on the issue, and a proposed response for public enquiry.

The federal government cannot force the CHA criteria upon a province. All it can do under the Act is to impose a financial penalty to the non complying province.In those cases where non compliance may have been an issue, the Directorate warned the Minister that he/she may have to eventually act under sections 14-17 of the CHA or that non action might leave him/her open to declaratory action in the courts. As of now, these sections of the Act have never been invoked. However it should be noted that the decision to undertake such action is the prerogative of the Minister, not of the Directorate.

The mechanism for communicating information to the Minister has changed over time. For example, in 1987, the mechanism of communication was largely one of Memoranda to the Minister. More recent communications were in the form of "Anticipated Questions for the House of Commons". Files for 1991 and 1992 indicate the Policy, Planning and Information Branch and Legal Services were at least informed, if not consulted on many issues.

Effectiveness in Monitoring and Assessment

The Health Insurance Directorate has a procedure to monitor and assess compliance. The positions taken on issues have been consistent over time as well as across provinces and within the spirit of the 1985 Minister's letter. The Directorate has also informed the higher authorities of the Department about cases of possible non-compliance.
Given the context in which it operates, the Directorate has been fulfilling its mandate effectively.

There are however a few issues that should be taken into consideration in assessing the monitoring activities:

1. The Directorate still basically operates under the general guidelines outlined in the 1985 Minister's letter which was rather accommodating. The interpretation manual has never been updated and approved officially. There is also the absence of regulations concerning the provision of information by the provinces (except in the case of user charges and extra-billing). There are also limitations imposed by the provisions of the Canada Health Act which leaves the definition opened to interpretation. Furthermore, the Act does not prescribe any process for investigation in cases of possible non compliance; instead, the Act leaves it to the discretion of the Minister to initiate a consultation process. This affects the ability of the Directorate to investigate or conduct in-depth analysis of potential compliance issues.

   In this context, the Directorate appears to have little choice but to rely on the review of provincial legislation, press clippings, provincial reports, the literature and formal and informal discussions with provincial officials for its monitoring function. The disadvantage of this method is that the Directorate may become aware of potential problems only when they become public or when these problems are brought to its attention . As the Directorate does not have the authority to undertake investigation to determine the scope and severity of potential problems, it has to rely on the provinces for information or clarification or on the "lack of evidence" that a given issue may indicate a contravention of the Act. Consequently, there may be cases where the Directorate could find itself in no position to reassure the members of parliament or the

Canadian public that provincial plans are meeting the criteria of the Act.

As mentioned previously, there have been relatively few incidences of non compliance and the Directorate's methods of monitoring and assessing may have been adequate in the past but, given the changes happening in the health care system and the increasing concern over costs, is this method going to be sufficient in the future? There is much concern in the public about the potential effects of cost containment and the Federal Government may be perceived as abdicating its responsibilities.

The literature and other documents reviewed for this study failed to turn out any non compliance case that the Directorate is not aware of. On the basis of the file review and of the literature search, it can be concluded that the criteria, as interpreted by the Department, have largely been met. There is no challenge in the literature to this general conclusion.

2. The Health Insurance Directorate has been consistent in its interpretation of the criteria. However, in the case of accessibility and comprehensiveness, it is not always clear under what circumstances the Department would consider there has been a contravention of the Act. This is of particular concern with respect to the criteria of comprehensiveness and accessibility.

3. The Directorate has advised the higher authorities of the Department of cases of possible non compliance and on the fact that the provisions of the Act could be invoked to initiate the necessary process to impose discretionary penalties. However, this section of the Act has never been invoked. In cases of non compliance (e.g., Quebec and Nova Scotia portability), the federal government has been clearly reluctant to use the power of the Act, preferring to use persuasion and discussion to solve the issue.

4. While the Health Insurance Directorate is effective in identifying issues related to the criteria of the CHA, it is not clear, how effectively it monitors the status of the health care system, including the implications of emerging issues for the underlying principles of the Canada Health Act. Interpretations reflect a focus on compliance of provincial plans with CHA criteria. There are issues which may not technically contravene provisions of the CHA but nonetheless may threaten the underlying principles of the CHA.[38]

For example, while the existence of waiting lists may not technically contravene the provisions of the CHA, they may be indicative of

"erosion" of the "principles" of the CHA. HID is aware of existing concerns about waiting lists for specialist services (as evidenced by briefing materials). There does not appear to be a coordinated or systematic effort to study the problem. Yet, HID acknowledges there are weaknesses in existing data on waiting lists. This raises the question of whether it is within the mandate of the Health Insurance Directorate (or any other NHW responsibility centre) to monitor issues of national concern which are not directly compliance issues but fundamentally linked to the "health" of the Canadian health care system.

5. Faced with increasing health care costs, provinces have been looking at ways of improving the efficiency of their health services and changes they are introducing may challenge the criteria of the Canada Health Act. The Directorate has recognized this changing environment and, in recent years, has become much more proactive. The Directorate has clearly recognized that the CHA criteria need definitional work in order to have a common understanding of their meaning and to determine where there is flexibility for provinces to pursue changes to their health care delivery systems. Efforts are currently underway to define or clarify the criteria in a cooperative fashion.

   HID officials have started to visit provinces and territories to discuss CHA interpretation issues. The Directorate is currently working on (and intends to continue its efforts) to draft interpretation guidelines such as those recently developed on out-of-country portability. The Advisory Committee on Institutional and Medical Services (ACIMS) is being used as a forum for discussion. The result should be a set of official interpretations covering all criteria, confirmed by the Minister of NHW.[39]

   It is recognized that there are trade-offs involved in more clearly defining the CHA criteria. Trade offs are between flexibility for the provinces to adapt their health care delivery to changing circumstances and establishing some standard for ensuring compliance with the principles of the CHA. Defining criteria more clearly must be done with the provinces as the specifics with respect to health care delivery are within provincial jurisdiction.

   While HID and PPI are beginning to discuss with provinces where there is flexibility for change within the provisions of the CHA, it should be noted that the Department's Health Services Directorate is working at the operational level to assist provinces in seeking more cost effective health care alternatives. While all three organizations

are pursuing what appears to be consistent objectives and are all working cooperatively with provincial governments, it is important that Departmental efforts be coordinated and that respective responsibilities be clearly defined.

ENDNOTES

1. User fees or user charges are charges for an insured health services that is not payable directly or indirectly by a provincial health care insurance plan.

2. "extra billing" refers to the billing for an insured health service of an insured person by a medical practitioner or dentist in an amount over an above the amount covered by the health care insurance plan.

3. Minutes of Standing Committee on Health Welfare and Social Affairs, January, 1984, Issue No.1.

4. The descriptive material herein is an amalgamation and synthesis of information contained in a number of different source documents. Much of the text is drawn directly from the following: the 1985 Letter from the Minister of National Health and Welfare to the provinces, the 1984 Policy Interpretation Manual prepared by the NHW Policy Planning and Information Branch, a draft discussion paper produced by the Health Insurance Directorate (November 8, 1991) The Need for Federal-Provincial Dialogue on Administration of the Canada Health Act, Ministerial speech notes, December 1991, statements from the Canada health Act, Annual Report, 1990-91, and briefing material prepared by the Health Insurance Directorate 1989 and 1990.

5. Each provincial plan is, in fact, structured differently.

6. Policy Interpretation Manual, 2-7

7. Departmental documentation refers to a "Patient Care Classification" developed by a Federal/Provincial Working Group as a possible basis for defining acute and rehabilitative care. To date, concerns regarding the definition of these terms have not been raised in the context of the Canada Health Act.

8. While services for the mentally ill are excluded from insured hospital services, all provinces provide them.

9. Health Insurance Supplementary Fund NHW 694 A 91-85).

10. "In general, the issue of what is or is not considered extra-billing rests fundamentally on the definition of "insured services" (Ref. PPI Manual).

11. "Only in extreme cases where a province reduced the supply of insured services to the point of virtual non availability or did not cover medically necessary services available elsewhere might it be considered non compliance", excerpt from Draft Discussion Paper on the Need for Federal-Provincial Dialogue on Administration of the Canada Health Act., HID, HSPB, Nov. 8, 1991.

12. The Department recognizes that it is economically unfeasible to provide a full range of services and facilities in geographically remote areas.

13. 1985 Letter

14. Draft HID's Letter.

15. 1985 Letter.

16. PPI Policy Interpretation Manual, 1984, p. 6-8.

17. 1985 Letter.

18. The Health Action Lobby (HEAL) is a lobby group of seven national health associations (Canadian Hospital Association, Canadian Long-Term Care Association, Canadian Medical Association, Canadian Nurses Association, Canadian Public Health Association, Consumer's Association of Canada, and Canadian Psychological Association. Its interest are in protecting the national principles of the Canadian health insurance programs as defined in the Canada Health Act.

19. Martin S. "Women's reproductive health, the Canadian Charter of Rights and Freedoms and the Canada Health Act" Canadian Council on the Status of Women 1989

20. Health and Fiscal Policy: Balancing the Objectives, HEAL, June 1992

21. Presentation to the Conference of Deputy Ministers of Health, HWC, January 1992

22. HEAL, October 1991

23. United States General Accounting Office. Canadian health insurance: lessons for the United States, 1991

24. State of Oregon, Canada's health care system, 1990

25. Jacobs P. et al. "Admission waiting times: a national survey" CJMAJ January 1987

26. Globerman, S. and Hoye, L. "Waiting your turn: a national survey" Dimensions in Health Services 67(1):32-34

27. Amoko Donald et al. "Surgical waiting lists I: Definition, Desired Characteristics and Uses" Health Care Management Forum, Summer 1992

28. Naylor David C. "A different view of queues in Ontario", Health Affairs, Fall 1991

29. Amoko et Al. "Surgical Waiting Lists II: Current Practices and Future Directions Using the Province of British Columbia as a Test Study", Healthcare Management Forum, Winter 1992

30. Jacobs P. et al. "Admission waiting times: a national survey" Dimensions February 1990

31. United States General Accounting Office, Canadian health insurance: lessons for the United States, 1991

32. Amoko et Al. "Surgical Waiting Lists I: Definition, Desired Characteristics and Uses" Healthcare Management Forum, Summer 1992

33. The only HID position which may assist in this regard is the HID response to strike situations. That is, where there have been service withdrawals due to strikes, HID has stated if emergency services are still being provided, there is no contravention of the CHA. On the other hand, there is reason to believe that even if emergency services were affected, where this was not the direct result of a deliberate action as reflected in a provincial plan, it would not be considered a contravention of the CHA. (HID File: 121-1991 Manitoba Nurses Strike (Access: Reasonable Access)

34. HID Files: 1208-1989;928-1989;421-1989; 427-1990; 403-1992 HID Files 403-1992, 427-1990, 1205-1988 (Access: Reasonable Compensation) HID File: 1220-1989 (Physician Shortages in Manitoba: Anaesthetists.) File: 828-1987, 423-1987 (Access to Abortion, Alberta)

35. It appears that a large proportion of events or issues which HID identifies is through the monitoring of newspapers, radio and television airings. In 1987 26 of 36 Ministerial briefings related to "reasonable access" were prompted by newspaper articles, radio or television airings. In 1992, at least 6 of 13 briefings resulted from media reports.

36. (i) Provinces are requested annually to submit information to the Health Insurance Directorate on their provincial plans. This information provides the basis for Annual Reports to Parliament.

    (ii) Almost all provinces have appointed Task Forces or have undertaken reviews of their health care delivery systems in recent years.

37. For example, professional associations have approached the Department concerning provincial capping of payments to physicians. Several individuals have requested Departmental assistance where they were asked to pay for insured medical care in advance.

38. Examples of such issues include:

    Accessibility:

    - growing references to waiting lists for specialist services. (File: 125-1992)

    User Fees:

    - reduction in the number of days in which a patient is considered "more or less permanently resident" in hospital such that charges can be levied sooner for accommodation and meals (File: 331-1987)

    User Fees/Universality

    - physician opting out for selected "elective" but not "emergency" services (to provide more ready access to those who do not wish to wait) (File: 325-1991)

39. HID File 612-1992 Public Administration (Speaking points for DM at June meeting of DM's of Health)